ATTACHMENT 2.10
NEW YORK STATE DEPARTMENT OF HEALTH
HEALTH CARE REFORM ACT - PUBLIC GOODS POOL

PROVIDER NAME/ADDRESS CHANGE FORM

Instructions: *Self-explanatory. Complete form if your facility had a name and/or address change.*

FEDERAL TAX ID#: _____ OP-CERT#: _____

PREVIOUS PROVIDER NAME: _____

PREVIOUS ADDRESS: _____
_____
_____

NEW PROVIDER NAME*:_____

NEW ADDRESS: _____
_____
_____

***Is your name change the result of a merger?** □**YES** □ **NO**

If yes, please fill out an Attachment 2.11, "Change of Designated Provider Status" form, and mail with this form to address below.

COMMENTS:_____
_____
_____
_____

NOTE: To verify what our records currently reflect for your name and address, please visit our website at the address below:

www.health.state.ny.us/nysdoh/hcra/provider.htm

SIGNATURE:_____

TITLE: _____

PHONE #: _____

DATE: _____

Please mail completed form to:
Mr. Jerome Alaimo, Pool Administrator
Office of Pool Administration
Excellus BlueCross BlueShield, Central New York Region
P.O. Box 4757
Syracuse, New York 13221-4757